J & K CONSULTANTS, INC.

2605 NICHOLSON ROAD – SUITE 140
SEWICKLEY, PA 15143
877-872-4232 • FAX 724-934-3328

HAMILTON COUNTY
MEDICAL EXPENSE REIMBURSEMENT CLAIM FORM

Employee Name: _____
LAST 4 OF SOCIAL SECURITY NUMBER:_____**DATE OF BIRTH:**_____
Please list dependent if the claim applies:
Spouse: _____
Children: _____
_____

Prescription Co-Pays:

Date: _____ **Name of drug:** _____ **Co-Pay amount:** _____
Date: _____ **Name of drug:** _____ **Co-Pay amount:** _____
Date: _____ **Name of drug:** _____ **Co-Pay amount:** _____
Date: _____ **Name of drug:** _____ **Co-Pay amount:**_____
Date: _____ **Name of drug:** _____ **Co-Pay amount:**_____
Date: _____ **Name of drug:** _____ **Co-Pay amount:**_____
Date: _____ **Name of drug:** _____ **Co-Pay amount:**_____
Date: _____ **Name of drug:** _____ **Co-Pay amount:**_____

Doctor's Office Visits:

Date of visit: _____**Co-Pay amount:** _____
Date of visit: _____**Co-Pay amount:** _____
Date of visit: _____**Co-Pay amount:** _____
Date of visit: _____**Co-Pay amount:** _____

Explanation of Benefits: EOB

Date of Service _____**Amount owed:** _____
Date of Service _____**Amount owed:** _____
Date of Service _____**Amount owed:**_____
Date of Service _____ **Amount owed:**_____

Please Note: All medical claims must be first submitted through your health plan. An explanation of benefits (EOB) is then provided. Only medical expenses that are approved by the plan will be reimbursed. For example, a drug that is not covered by the drug card (not on the formulary list) or a NON-medical expense will not be reimbursed. Failure to provide all information will cause delay in reimbursement.

*****************************Employee's Statement*******************************

I hereby certify that the information contained on this Reimbursement Claim Form is to the best of my knowledge and belief true and correct and each item is eligible for reimbursement. I certify that the amounts above have not been reimbursed under any other health care plan or program, federal, state, or government program, worker's compensation, or any other policy of health insurance, and that I will not seek reimbursement under any of the aforementioned plans. I understand that any expenses reimbursed are NOT tax deductible on my Federal Income Tax return.

Date:_____**Employee Signature:**_____

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